



CHILD CARE ASSISTANCE APPLICATION
ND DEPARTMENT OF HUMAN SERVICES
SFN 598 (Rev. 06-2004)

FOR OFFICE USE ONLY

Date Requested:

Date Received:

APPLICATION DEADLINES

Eligibility begins on the first day of the month in which an application is requested from the county social service office, provided the family submits the completed, signed, and dated application by the 10th of the following month. If it is not received by that date, assistance will begin with the month the application is received.

ALL REQUIRED VERIFICATIONS (income, child care bill, class schedule, and, if attending school, "SFN 113, Child Care Assistance Program Postsecondary Education Information" and postsecondary transcripts) MUST BE RECEIVED WITHIN 45 days of the application. Without complete verification, your application will be denied. You have the right to appeal if you do not receive written notice of the action taken on your application within 60 days after receipt of your application, or if you believe the action taken is wrong.

APPLICATION INSTRUCTIONS

Please print or type your answers. Read all instructions carefully and answer each question fully. Attach another sheet if you need more space. Failure to answer each question may delay receipt of assistance. Eligibility for assistance will be determined by the **county social service office**. Sign and return this completed application to your local county social service office. If you have any questions about completing this application, call your local county social service office. **Incomplete applications will be returned to you.**

First Name		Middle Initial	Last Name		
Mailing Address		City	State	Zip Code	County
Home Telephone Number			Work Telephone Number		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single					
Have you ever received or applied for Child Care Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, when?		
Where?			What name did you use?		
Have you received North Dakota Temporary Assistance for Needy Families (TANF) in the last three months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, which county?					

I. HOUSEHOLD SIZE

List: **All** people currently residing in your household including you.

Name (Last, First, Middle Initial)	RELATIONSHIP	SOCIAL SECURITY NUMBER *	BIRTH DATE	SEX	RACE
	SELF				

*Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose social security number will not affect participation in this program.

Is any household person temporarily out of the home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of absent person:	Relationship to children receiving child care assistance:
Reason for absence:	
Expected date of return:	

II. EMPLOYMENT/TRAINING INFORMATION

IF YOU OR SECOND PARENT ARE WORKING, COMPLETE THE FOLLOWING.

IF YOU OR SECOND PARENT HAVE MORE THAN ONE JOB GIVE SAME INFORMATION FOR EACH JOB.

ATTACH VERIFICATION OF WAGES.

Wage Earner				Wage Earner				Wage Earner			
Employer				Employer				Employer			
Date Income Received	Hrs	Gross Wages/Commission	Tips	Date Income Received	Hrs	Gross Wages/Commission	Tips	Date Income Received	Hrs	Gross Wages/Commission	Tips
How Often Is This Person Paid? ("X" Below) <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Other <input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks				How Often Is This Person Paid? ("X" Below) <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Other <input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks				How Often Is This Person Paid? ("X" Below) <input type="checkbox"/> Monthly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Other <input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks			
Day of the Week Paid ("X" Below) <input type="checkbox"/> Monday <input type="checkbox"/> Wednesday <input type="checkbox"/> Friday <input type="checkbox"/> Sunday <input type="checkbox"/> Tuesday <input type="checkbox"/> Thursday <input type="checkbox"/> Saturday				Day of the Week Paid ("X" Below) <input type="checkbox"/> Monday <input type="checkbox"/> Wednesday <input type="checkbox"/> Friday <input type="checkbox"/> Sunday <input type="checkbox"/> Tuesday <input type="checkbox"/> Thursday <input type="checkbox"/> Saturday				Day of the Week Paid ("X" Below) <input type="checkbox"/> Monday <input type="checkbox"/> Wednesday <input type="checkbox"/> Friday <input type="checkbox"/> Sunday <input type="checkbox"/> Tuesday <input type="checkbox"/> Thursday <input type="checkbox"/> Saturday			

Are you or the second parent self-employed? ☐ Yes ☐ No If yes, the individual who is self-employed will be required to provide a ledger of income and expenses or income tax reports, depending on the type of self-employment, for verification of income.

Does your household need financial help with child care because you or the second parent go to postsecondary school or training?
☐ Yes ☐ No

A COPY OF "SFN 113, CHILD CARE ASSISTANCE PROGRAM POSTSECONDARY EDUCATION INFORMATION", AND YOUR SCHOOL SCHEDULE MUST BE ATTACHED.

III. INCOME

UNEARNED INCOME: This section must be completed for each household person including all children, parents, and stepparents. Check each item "yes" or "no". If "yes", show the amount received, who received it, date received, and attach verification.

INCOME	YES	NO	AMOUNT	DATE RECEIVED	WHO RECEIVES
Child Support/Alimony					
Food Stamps					
IIM (Individual Indian Monies)					
Mineral Lease Income					
Public Assistance (TANF, GA, etc.)					
Railroad Retirement					
Rental Income					
SSA (Social Security)					
SSI (Supplemental Security Income)					
Unemployment Benefits					
Veterans Benefits					
Worker's Compensation					
Other (Specify)					
If receiving housing assistance paid on the household's behalf, enter the monthly amount					

IV. CHILD CARE NEEDS

List each child requiring child care, age, whether or not the child is in school, average number of child care hours required per week, and the name(s) of the child care provider(s).

Child's Name	Age	In School? Yes/No	Average Number of Hours Required Per Week	Name(s) of Child Care Provider(s)

I understand that the amount of child care assistance I receive will be based on the information I have provided on this form. I also understand that the amount of child care assistance may be changed without advance notice. I understand that social services will verify the information I have provided, and that federal and state laws provide for fines and/or imprisonment of any person who fraudulently receives, or attempts to receive public assistance to which he or she is not entitled. I understand that I must report all changes in household size, income and child care provider. I understand that I am responsible for paying my percentage of child care costs and any additional costs over the allowable maximums not covered by the program. I declare and affirm under penalty of perjury that, to the best of my knowledge, the information I have provided herein is true and correct.

SIGN HERE	Signature of Applicant	Date
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AUTHORIZATION TO FURNISH/RELEASE INFORMATION

Please read and sign the authorization to furnish or release information for verification of wages, student status, and child care costs. **This authorization must be signed in order to process your application.**

TO WHOM IT MAY CONCERN:

I hereby authorize any person, agency, or institution to supply information, other than protected health information, concerning me or my family requested by County Social Services and to allow inspection and reproduction of records in their possession by any duly authorized representative of County Social Services.

I further authorize County Social Services to release such information, other than protected health information, to cooperating state or federal agencies. I authorize County Social Services to inform my provider(s) of my eligibility or ineligibility of payment for child care.

I release any person, agency, or institution from any and all liability to me or my family for supplying such information, other than protected health information.

This authorization is given only in connection with its use by County Social Services in its administration of the Child Care Program and for no other purpose.

SIGN HERE	Signature of Applicant	Date
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Return Completed Application to Your Local County Social Service Office.



INFORMATION, RIGHTS AND RESPONSIBILITIES FOR THE RECIPIENT OF THE CHILD CARE ASSISTANCE PROGRAM
ND DEPARTMENT OF HUMAN SERVICES
SFN 598 (06-04)

KEEP THIS INFORMATION FOR FUTURE REFERENCE
APPLICATION - PART I

PURPOSE OF PROGRAM

- To help with child care costs for families within income limitations while they are working and/or are in an approved educational activity.

APPLICATION

- Eligibility begins on the first day of the month in which an application is requested from the county social service office, **provided** the family submits the completed, signed, and dated application by the 10th of the following month. If it is not received by that date, assistance will begin with the month the application is received.

ELIGIBILITY

- To be considered for the program, complete the attached application and submit it to the local county social service office.
- An applicant must verify **ALL** income, earned and unearned, for **ALL** members of the household. This is needed in order to determine eligibility and calculate benefits.
- Persons attending college or other training need to submit form "SFN 113, Child Care Assistance Program Postsecondary Education Information," along with postsecondary transcripts and a class schedule.

CHILD CARE BILLING FORM, SFN616

- This form must be used to report days and actual hours your child is in day care.
- It is the **provider's** responsibility to complete the form each month with the **actual** hours of care provided.
- The form must be signed by both you and your provider after it is completed to be valid.
- You must submit the form to the county social service office along with the monthly verifications and information listed below.

FAILURE TO SUBMIT ALL REQUIRED VERIFICATIONS WITHIN 45 DAYS
WILL RESULT IN THE DENIAL OF YOUR APPLICATION.

PROVIDER INFORMATION

- Your provider must be at least 18 years of age.
- Your provider must be self-certified, registered, licensed, or an approved relative. The approved relative must be specifically approved for your child(ren).
- Your provider **must complete a "W-9, Request for Taxpayer Identification Number and Certification"**, and submit it to the state office before payment can be made to either provider or parent. If your provider moves or changes provider type, the department needs an updated W9.
- Your provider may choose whether he/she or you will receive the payment. The **provider** must give a written statement to the county social service office if the payment is to go to you.

**IT IS RECOMMENDED THAT YOU SUBMIT THE MONTHLY VERIFICATIONS
BY THE 5TH OF EACH MONTH SO YOUR WORKER CAN DETERMINE
ELIGIBILITY AS QUICKLY AS POSSIBLE.**

MONTHLY VERIFICATIONS

- **Each month** you must submit verification of all income, changes in household members, the "SFN 616, Child Care Billing" form, any change in provider(s), and any other information that may affect your eligibility for Child Care Assistance.
- Payment may be delayed or your case may be closed if you fail to submit all verifications.

MONTHLY DEDUCTIONS

- Child support and court ordered spousal support paid, including arrearages paid by a child care assistance family, is a deduction from the family's income. Proof of payment must be provided each month.

RIGHTS OF APPLICANT OR RECIPIENT

- Right to prompt written notice of any decision concerning your application or grant and the reason(s) for such decision;
- Right to review the policy manual during normal business hours;
- Right to be treated with courtesy and respect by agency personnel;
- Right of freedom from any violation of your privacy or personal dignity or any infringement of your constitutional rights;
- Right to confidentiality concerning your circumstances except as they may relate directly to the administration of the program;
- Right to be assisted by any person you choose in any dealing with the county social service office;
- Right to request a hearing before the Department of Human Services if you believe that an action taken which affects your eligibility or benefit amount is incorrect. This request must be made within 30 days of the action; and
- Right to file a written complaint if you believe that you or members of your family have been unlawfully discriminated against by reason of race, color, religion, sex, national origin, age, political beliefs, handicap, or status with respect to marriage or public assistance. Contact your local county social service office or the state office to file the complaint.

If you have further questions about this application or requirements of the program, you may contact your local county social service office.